Response To Flather-Morgan’s “Caring For Patients With Dysphagia: Some Ethical Considerations”

Michael E. Groher

Flather-Morgan has provided us with an eloquent introduction to ethical considerations in caring for patients with dysphagia. Since her background is as a pulmonologist in critical care, I would hope that in the future we can call upon her as a resource to provide us with some ethical dilemmas that she undoubtedly has faced in providing alimentation for dysphagic individuals. It seems to me that only by specific case examples can we come to learn the ethical and legal ramifications of managing patients who are unable to swallow. I would like to emphasize three main points from her paper: first, that treatment decisions always occur in the context of relationships; secondly, that controversy continues to exist surrounding the issue of whether or not the provision of food and fluids constitutes medical treatment; and finally, that we need to do our best to educate our patients and family members about treatment outcomes, including nonmedical outcomes such as quality of life.

Decisions regarding feeding or nonfeeding of dysphagic patients routinely involve many complex interactions between physician and patient, surrogate, or other family members, and among members of the interdisciplinary dysphagia team, each with his or her own perspective. The complexity of these relationships is evidenced by the fact that rarely do we make the same decisions for identical dysphagic presentations. Each individual presents with a unique set of medical circumstances, and a unique set of beliefs as they relate to their medical care.

Most of the court decisions in the United States pertinent to the termination or institution of feeding have concluded that the provision of food and fluids by tube is to be considered a medical treatment. If we accept that feeding tubes are medical treatments, their use must be subjected to the traditional risk/benefit analysis. This information must be conveyed to the patient and/or surrogate before a treatment decision is finalized. Treatments in this circumstance are made by mutual consent of the patient and health care team. The patient or surrogate will either accept or reject the treatment offered, and most often this decision will be honored. Some cases have come before the court in which a medical treatment clearly was in the patient’s best interest, but the surrogate refused, forcing the medical center to attempt to either discharge the patient or provide the treatment. However, if giving food and fluids is not viewed as a medical treatment (and this has been the view of numerous local hospital ethics committees) the medical center will offer food and fluids as part of routine, basic care. That is, as long as the patient consents to be hospitalized, he or she will be given food and fluids as a routine part of care.

As a speech-language pathologist working on a dysphagia team, it is difficult for me to separate medical treatment outcomes from those that Flather-Morgan has termed “nonmedical,” or quality of life issues. This is particularly relevant for those patients who are under consideration for exclusion of oral feeding. One of the most gratifying pleasures one would hope to maintain, especially in progressive or terminal illness, is oral alimentation. If the treatment team decides that tube placement is the most efficacious medical option, this must be weighed against the obvious compromise to one’s quality of life, i.e., some treatments provide positive physiologic effects with no real benefits. Educating patients on the risks and benefits associated with oral and nonoral alimentation is difficult due to the lack of prospective data from homogeneous populations. For instance, what are the real risks of continuing to feed a patient who is aspirating? Some will tolerate their aspirant better than others. Clearly how well they do will depend on the amount and characteristic of the aspirant, and on other suspected contributors such as age, health status, feeding dependence, and mobility. Similarly, tube feeding may enhance the quality of life for some patients, whereas in others it may increase their chance for aspiration and the morbidity and mortality that is associated with it.